



Authorization for Disclosure of Protected Health Information

Patient Name _____
 Address _____
 City, State, Zip Code _____

Previous last name(s) _____
 Date of Birth _____
 Telephone _____

I authorize the use and/or disclosure of my protected health information:

I understand that my protected health information that I am authorizing to be disclosed may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), infection with the Human Immunodeficiency Virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. **If I do not intend for this information to be disclosed, I understand that I will need to cross out the statement above and initial here.** _____

FROM:

TO:

Organization/Provider _____
 Address _____
 City, State, Zip _____

Organization/Individual _____
 Address _____
 City, State, Zip _____
 Phone Number _____ Fax _____

Information to be disclosed includes:

Hospital Record:	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Emergency Report
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Consultations
<input type="checkbox"/> Lab/Pathology Reports	<input type="checkbox"/> EKG Reports
<input type="checkbox"/> Operative/Procedure Report	
<input type="checkbox"/> Radiology/X-Ray Reports	
<input type="checkbox"/> Other _____	

Clinic Record:
<input type="checkbox"/> Office Visit Notes
<input type="checkbox"/> Radiology/X-Ray Reports
<input type="checkbox"/> Lab/Pathology Reports
<input type="checkbox"/> EKG Reports
<input type="checkbox"/> Other _____

Delivery Method:
<input type="checkbox"/> Pick-Up
<input type="checkbox"/> Mail
<input type="checkbox"/> Other _____

Dates of Service: _____

Purpose for disclosure (Optional):

- | | | | |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Personal | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Social Services | _____ |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Worker's Compensation | | _____ |

Fees: I understand that fees may apply to process my medical record request.

Further Disclosure: I understand that, if the persons or organizations I am authorizing to receive and/or use the protected health information are not subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Right to Revoke: I understand that I may revoke this authorization in writing at any time, except to the extent that the authorization was acted upon prior to revocation.

Right to Review: I understand I have the right to inspect and receive a copy of the materials to be disclosed.

Expiration: This authorization is effective for six months from the date signed, or on occurrence of the following event (Specify): _____

I understand that treatment, payment, enrollment in a health plan or eligibility of benefits may not be conditioned on my decision to sign this authorization, except as provided in federal health information privacy laws.

A copy of this authorization is as valid as the original. I understand that I am entitled to a copy of this authorization after I sign it.

Signature of Patient _____

_____ Date

Signature of Parent/Legal Representative _____

_____ Relationship

_____ Date